

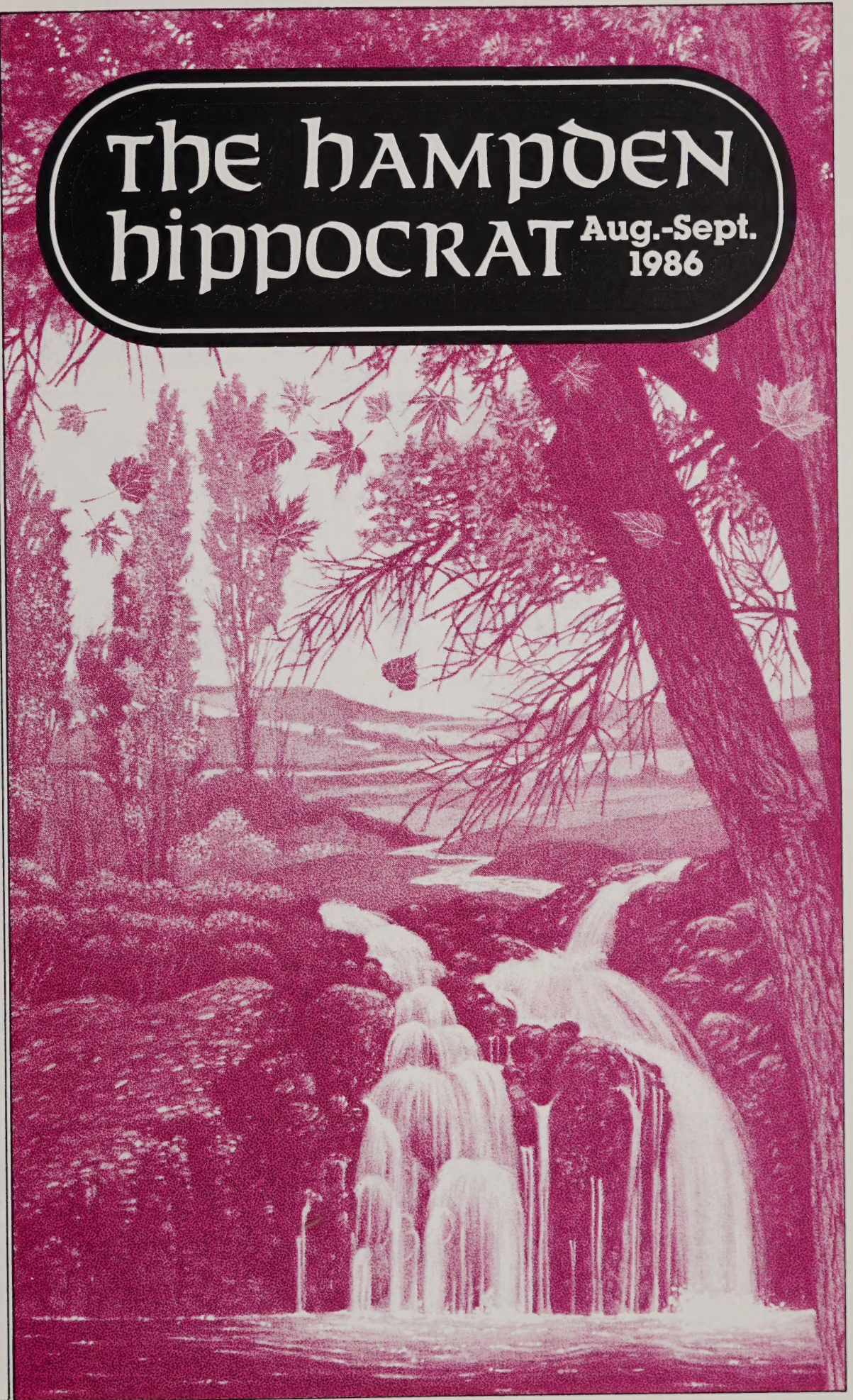
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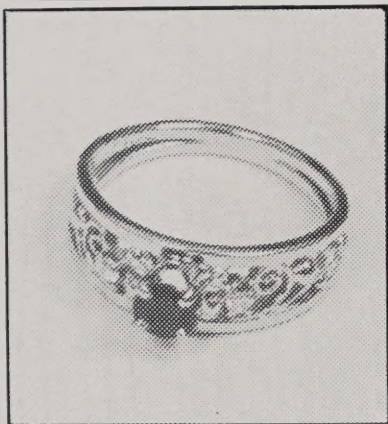
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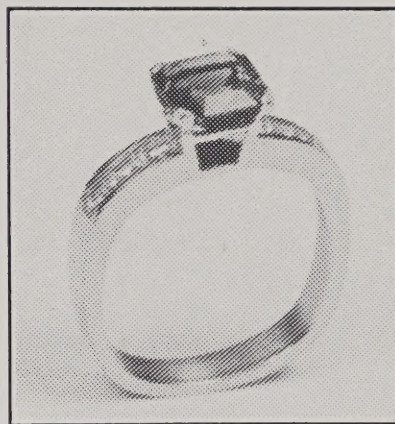
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THE HAMPDEN HIPPOCRAT

VOLUME XXXXII NO. 11
AUGUST — SEPTEMBER 1986

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DISTRICT MEETING

PLACE:	Chez Josef Shoemaker Lane, Agawam
DATE:	Tuesday, September 23, 1986
BUSINESS MEETING:	6:00 P.M.
SOCIAL HOUR:	7:00 P.M.
DINNER:	7:30 P.M. Spouses are Welcome
SPEAKER:	Mark Shields Columnist, Television Political Commentator for CBS
SUBJECT:	"The Wit & Wisdom of Mark Shields"

NOTE: If you must cancel your dinner reservation, please call the office before noon on September 23rd. If the cancellation is not made you will be billed for your dinner.

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AUGUST — SEPTEMBER 1986

VOLUME XXXXII NO. 11

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D., and William A.R. Chapin, M.D.

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The opinions expressed in this bulletin are those of the writers and do not reflect the official viewpoint of the Hampden District Medical Society unless so stated.

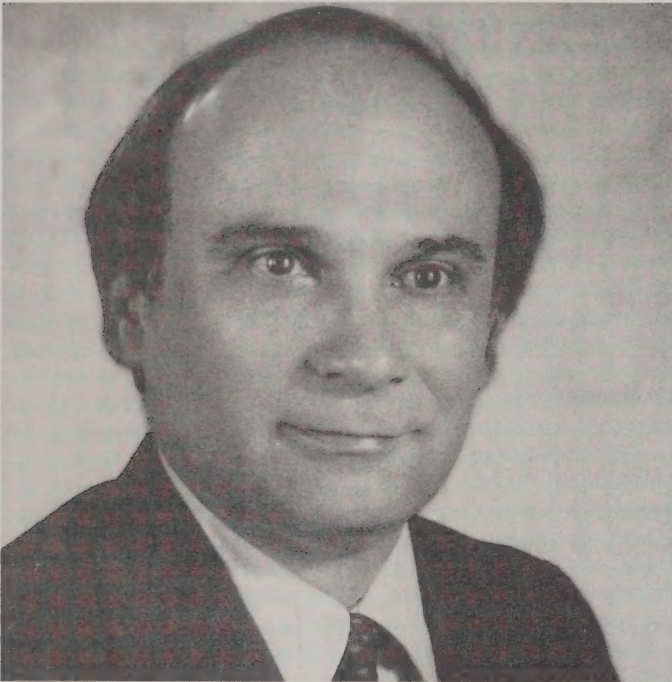
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HDMS President's Message

Malpractice Post Mortum



Gregory A. Slachta, M.D.

Over the past two years we have worked tirelessly in the area of tort reform in order to develop a system of realistic and reasonable compensation for patients who are victims of negligent practice. This compensation must be at a price that the physicians, through liability insurance premiums, and the citizens and the businesses of the Commonwealth, through medical insurance premiums, can afford. It must also redefine negligent practice, hence, tortfeasance, from maloccurance, which is better addressed as disability compensation. It must redefine insurability and responsibility for this difference.

Where were we two years ago and where are we today? Two years ago the Massachusetts Medical Society filed ten bills in the legislature that were fashioned after California's successful reform package. These ten bills could not be moved out of committee at that time. Today, we have legislation passed and signed in an attempt to remedy the problem. [Chapter 351 of the General Laws, an Act relative to Medical Malpractice]. This was a victory of form, but only a small victory of substance. This is not meant to minimize the effort that was undertaken but to magnify the edifice that needed to be scaled. Tort reform and malpractice premium relief is an ongoing battle between several opposing forces that play their political cards in many different ways and in different forums. Very few states have obtained significant tort reform in their early efforts. Many have needed to maintain a legislative vigilance to protect those gains, often defending legal challenges to the Supreme Court (and winning) as well as to protect those gains. California (Prop 51) has bypassed the legislature and gone successfully to the people by referen-

dum to remove joint and several liability statutes recently. [just "California Dreamin'"] It is extremely difficult to pass legislation in *any* Statehouse that is heavily utilized for the overflow of the excessive production of barristers. Some of these also practice their profession and have a significant self-interest to protect their homes in absolute conflict of interest with the needs of the citizens of the Commonwealth.

The challenge is monumental but we are one step closer to the summit than we were when we started this journey. We accepted the challenge because it is essential to provide this Commonwealth with affordable and quality health care. Also because it is necessary to maintain an environment to entice new physicians to the community and not penalize those who have dedicated their lives to caring for their patients from a liability system's uncontrolled largess. Something must give and the physicians have more than contributed their share in restrained earning ability and in hours of work and dedication to their patients. It will have to be accomplished by significant tort reform and all elements of the compensation system paying their fair share: protected service companies (Blue Shield), the Commonwealth (Medicaid) and business (Workman's Compensation). We, (unlike the legislature has lauded), do not have a balanced bill. What we have is a temporary reprieve from financial catastrophe. This legislation was touted by the Massachusetts Bar Association as the best malpractice bill in the country. It would better be characterized as the *Attorney's Compensation Act of 1986*. It codified the status quo and did not put the brakes on a voracious tort system.

We have learned much from this legislative effort. These lessons will not be lost. We have become closer as a group through this effort and this will not be lost. We have developed new vigor in all our efforts and this will be used as a building block for the unification of the physician community. We have developed a new awareness in matters of legislation and this will not be lost. We have learned to meet and communicate with legislators and this will not be lost. We have developed a growing commitment of the entire physician community to participate and this will not be lost.

I take this opportunity to thank all of you who called me throughout this effort and asked how they could help and did; asked who they could call and did; asked whom they could write and did. You helped me immensely in maintaining my personal conviction that hard work and purpose is its own virtue but also that the cause was, and is, essential to maintain quality care to this community. Without you all, we could not have accomplished what was achieved. That was the real victory. It will put us in good stead for the future efforts necessary to achieve a healthy environment for practice and conducive atmosphere to be able to bring to the Commonwealth new physicians. My commitment to you is a redoubling of our efforts.

"There is one thing stronger than all the armies in the world, and that is an Idea whose time has come." —Victor Hugo

The Corporation and the Medical Profession

by Arnold S. Relman, M.D., Editor of the New England Journal of Medicine

Three brief news items in a recent issue of *American Medical News* (1) caught my eye. They all concern Humana, Inc., one of the largest of the investor-owned medical conglomerates.

One of the stories ("Care Plus will lose \$70 million, analyst says") tells about the financial losses suffered by Humana in launching its new health insurance program--called Care Plus. In an effort to fill its hospital beds, the company has been offering reduced premiums to subscribers who will use Humana facilities exclusively, but a just-released analysis by a financial consulting firm notes that the plan continues to lose money despite Humana's attempts to persuade physicians to refer their insured patients to company hospitals. The analysis goes on to say "the Humana physician [presumably this refers to doctors with admitting privileges at Humana hospitals] is still acting as an independent broker because he is not tied to the company..." and has "no financial incentive to behave." But Humana's investors should not worry too much: according to the financial analyst's report, the corporation will soon be able to deal with refractory physicians. "As unfolding market dynamics continue to erode physician power, Humana will be able to rein in Care Plus costs." The analyst concludes: "Humana's concept of intergrating hospital management with its own insurance program is a good one, however, which anticipates the way health care will be organized in the future."

A second news item ("Humana to Acquire Troubled Florida HMO") gives Humana investors more encouraging news. The company has signed a letter of intent to acquire International Medical Center, Inc. (IMC), a large privately-owned for-profit Florida HMO with 185,000 subscribers, including some 135,000 Medicare beneficiaries. No details of the proposed deal have been released but the sale price is presumably very large, since IMC's annual revenues are more than 400 million dollars.

Unfortunately, IMC is under federal investigation because of "complaints from Medicare patients concerning the quality of care and from providers who were not being paid properly." The government also charges that IMC does not have an acceptable quality assurance program. However, Humana will "assume all of IMC's responsibilities once the sale is completed," although "no drastic changes are planned," other than "improvement of service in places where it has been questionable."

Additional information about the proposed IMC-Humana deal comes from a recent stock research report on Humana by the investment banking firm of Salomon Brothers Inc. (2) The report was confident that Humana will take steps to correct any abuses committed by IMC. Since virtually every Medicare member of IMC's plan is within Humana hospital service areas, and since beneficiaries will be covered only for care in Humana facilities, the company is expected to increase its revenues and profits substantially. Salomon Brothers therefore gives Humana's stock its highest rating--presumably uninfluenced by the fact (disclosed in the report) that both the firm and the analyst who prepared the report hold investments in Humana.

The last of the news items in *American Medical News* ("HSA to Appeal OK for Humana Teaching Hospital")

reports that a suburban Chicago health planning agency is appealing a state ruling permitting Humana to build a 224-bed teaching hospital for Chicago Medical School in an area near the Illinois-Wisconsin border which is said not to need such a facility. According to the story, the suburban agency claims the area is already overbedded, tertiary care is within easy reach in Chicago and Milwaukee, and a new facility would force one or more of the seven hospitals in the area to close. The story reports Mr. David A. Jones, chairman of Humana, as concerning in a press conference that market competition may force as many as 25% of the nation's hospitals to close their doors or shift facilities to other purposes. "That happens in life," he was quoted as saying. The issue may not be settled for several months, but in the meanwhile, "Lobbyists for Humana had asked the state legislature to approve a bill that would have exempted the hospital proposal from state approval, but opponents were successful in killing the measure."

These stories are disturbing, not primarily because of what they say about the business strategy of an aggressive health care corporation. Humana, after all, is but one among many competing corporations using similar tactics to expand their market share and increase the flow of patients to their facilities. What I find most unsettling is the glimpse of the future state of our health care system afforded by these stories. If present trends continue, Humana-like conglomerates may soon dominate the financing and delivery of medical care in some parts of the country. A few successful conglomerates may be not-for-profit, but the current climate clearly favors investor-ownership and the for-profit philosophy.

Investor-owned corporations are more likely to have the centralized management, the instant access to large capital and the entrepreneurial drive needed to win the competition for larger market shares. Such corporations will probably grow the way Humana seems to be doing it, i.e., by using their economic power to capture insured patients, acquire new facilities and, ultimately, buy the cooperation of physicians. In the past, most large health care companies recoiled from the suggestion that they would some day hire physicians or otherwise seek to control physicians behavior. But that was in the days when physicians were the only source of paying patients for hospitals and had to be courted as customers. Now, with the ascendancy of contractual, prepaid arrangements and a growing surfeit of under-utilized young doctors, the corporations will depend on physicians not so much as sources of new patients but as employees, or contractors for the low-cost management of patients already under group contract. As the analyst in the *American Medical News* story noted, corporations wishing to prosper under prospective payment will need to exercise "tough control" over physicians. That will usually mean hiring or contracting with doctors, although in some circumstances companies may prefer to strike profit-sharing deals with solo practitioners to gain their cooperation. In any case, it is a prospect to give conscientious physicians pause for thought: the big corporations will be enlisting doctors to help them make profits by delivering low-cost care. Who, then, will protect the patients' interests? Will

Continued on next page

The Corporation and the Medical Profession

continued from previous page

the rule of commerce--*caveat emptor*, let the buyer beware--become the standard for medical care as well?

Some view the corporatization and commercialization of American health care as inevitable. In my opinion, however, this trend will not be inevitable unless it offers significant public benefit, and on that question there is room for skepticism. A recent in-depth study by the Institute of Medicine of the National Academy of Sciences (3) revealed no advantages of investor-ownership of hospitals. To the contrary, the study confirmed that investor-owned hospitals have been more expensive for payers and less willing to give charity care than not-for-profit hospitals. The study also emphasized the need for physicians to act as independent trusted agents for their patients, regardless of the ownership of health care facilities. The news items suggest, however, that this may be difficult if physicians increasingly come under the sway of powerful corporations.

The stories also suggest how the economic power of the investor-owned corporations can be used to force their way into local health service areas (even those that are overbedded), drive community hospitals and health services out of existence and influence political decisions. A health care system dominated in this way by giant for-profit conglomerates would be more a business than a social service. It would be directed from corporate headquarters, not local communities, and would primarily reflect the corporate commitment to the financial interest of investors rather than the communities' interests--the medical needs of all of their citizens.

Fortunately, the medical profession is not without its own power to influence events. The corporations have the money, but they cannot give medical care to patients--only physicians do that. The public still relies on physicians for advice about medical care and it will surely count on them to monitor the impact of commercial corporate ownership on the quality and accessibility of medical services. In the public's interest we doctor's should hold the corporations strictly to account, and should speak out whenever we perceive business actions threatening our patients' welfare or the ethics of our profession.



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We can do that only if we remain free of vested interests in the corporations and outside their control.

References

- (1) *American Medical News*, August 8, 1986, p.12
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 - (c) Scheier, R.L. HSA to appeal OK for Humana Teaching Hospital
- (2) Sherlock, D.B. Salomon Brothers, Inc. Health Services Stock Research. July 22, 1986
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Chapter 351 of the Acts of 1986

An Act Relative to Medical Malpractice

Over the past year we have heard a preponderance of news and information relative to the development of a solution to the liability insurance crisis. The first shot heard 'round the commonwealth was here in Springfield, Massachusetts in the City Council Chambers on October 3rd of 1985. Here, after one year of effort, is a summary of the legislature's answer to stem the crisis.

("What we hoped would be a ship of hope became a small raft." —Rep. Marjorie Clapprood, D-Sharon.)

I will attempt to summarize the Act in the following paragraphs.

Section 1: Placement of the Board of Medicine within the Executive office of Consumer Affairs. (The Board is no longer interested only in the medical qualifications of physicians)

Section 2: Adjustments in Medicaid Rates and Workman's Compensation Rates for Change in Medical Malpractice Premiums (In addition, the Rate Setting Commission will be required to assess both entities their respective market share of Medex rates)

Section 3: Authorizes Secretary of Consumer Affairs to Disapprove Rules and Regulations of the Board of Medicine.

Section 4: Establishes a Medical Malpractice Analysis Bureau within the Division of Insurance.

Section 5: Provides a definition of "Health Care Provider" for the purpose of the peer review process and mandatory reporting.

Section 6: Provides definition of "Medical Peer Review Committee"

Section 7: Expands obligation of hospitals to report Medical Staff disciplinary actions.

Section 8: Requires hospitals to file annual disciplinary summaries.

Section 9: Requires disciplinary bylaws in hospitals and participation by hospitals in risk management programs; grants civil immunity to peer review participants; provides confidentiality protection for peer review. (does not provide federal immunity from anti-trust suits)

Section 10: Limits authority of Director of Division of Registration over Medicine Board

Section 11: Changes cycle for renewal of physician's licenses.

Section 12: Authorizes Medicine Board to require financial responsibility for malpractice liability; requires Medicine Board to participate in national reporting systems.

Section 13: Reorganizes the Medicine Board's disciplinary process and expands the Board's investigatory powers (gives Board subpoena power)

Section 14: Reporting requirements; Disciplinary authority of the Medicine Board.

Section 15: Timetable for setting Medical Malpractice rates and authorization to establish rates for physicians practicing part time.

Section 16: Reports of the Insurance Commissioner shall be sent to the Special Commission on Medical Malpractice.

Section 17: Establishment of Interim Rates. [If premium charges are not effective for the application 12 month period (July 1-June 30), the Commissioner must establish the premium charges requested by one of the parties as the interim rate. When premium charges are finally fixed, they are effective as of July 1, and adjustments shall be made retroactively.]

Section 18: Adjustments to Payments by Blue Shield for changes in Medical Malpractice Premiums. (Blue Shield's payments to participating physicians and dentists shall be adjusted for changes in medical malpractice insurance policies, based on Blue Shield's share as well as the Medex share. Whenever Blue Shield's subscription charges are subject to regulation by the Commissioner, the Commissioner shall allow Blue Shield to pass along malpractice cost to subscriber's)

Section 20: Tribunal findings as evidence of frivolous claims. (The decision of a medical malpractice tribunal would be admissible as evidence in a case alleging that a medical malpractice claim was wholly, insubstantial, frivolous and not advanced in good faith.)

Section 21: Increase in the Tribunal Bond from \$2000 to \$6000. (Previously the bond was \$2000 per defendant; now it

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Chapter 351 of the Acts of 1986

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is \$6000 regardless of the number of defendants. It is now cheaper to shotgun the charge and the most the collective defendants can recover for defense costs is \$6000.)

Section 22: Complaints, Tribunal findings, dispositions of Medical Malpractice cases to be reported to the Board of Registration in Medicine.

Section 23: Statute of Limitations for Minors: Any claim by a minor alleging medical malpractice shall be filed within three years after discovery but in no case more than seven (7) years after treatment except where action is based upon leaving a foreign object in the body. A child less than 6 years of age would have until 9 years to commence suit.

Section 24: Itemized verdicts.

Section 25: Partial abolition of the Collateral Source Rule (Collateral sources are excluded from the date of the award in determining the dollar amount.)

Section 26: A \$500,000 cap on non-economic damages; Excludes cases where there is a substantial or permanent loss or impairment of bodily function...cases of substantial disfigurement...or cases of "special circumstances" (basically there is no cap at all.)

Section 27: Attorney's fees. This limits contingency fees by law but is merely a substantiation of the status quo. Massachusetts attorney can earn \$295,000 on a one million dollar settlement or verdict. In California an attorney can earn \$141,500 for the same award. (*Maybe the training and quality of the attorneys of Massachusetts justifies this largess*)

Section 28: Extends immunity to members of HMO peer review committees.

Section 29 and 30: Statute of Limitations — Adult. Again three years from discovery but in no cases greater than 7 years after incident except on action based upon leaving a foreign object in the body.

Section 31: Separate lines of business: The JUA, may upon the approval of the Insurance Commissioner, consider the business of each category of health care provider as a separate line of business.

Section 32: Expansion of Limits of Coverage: Coverage limits are expanded to allow purchasing \$2 million per claimant and \$6 million for all claimants.

Section 33: JUA Board of Directors: Restructuring the Board to 15 members from 13; 8 elected by members of the Association; 4 appointed by the Commissioner as representatives of the Medical Profession; 1 appointed by the Commissioner as a representative of the licensed hospitals; 1 appointed as a representative of insurance producers and 1 appointed to represent the public.

Section 34: JUA data repository

Section 35: Risk Management Techniques; the JUA shall, subject to the Commissioner's approval, impose discounts for participation in risk management activities.

Section 36: Surcharges and Credits: Surcharges will reflect the increased cost of defending physicians with more claims asserted against them than the average in their speciality during the previous 5 years. Credits shall be given to JUA insured physicians who have not had a malpractice action commenced against them over a period of time to be determined by the Commissioner.

Section 37: Extension of Joint Underwriting Association existence.

Section 38: Payment of retroactive premiums; Retroactive premiums assessed for policies between July '83 and July '86 shall be paid out beginning July 1, 1987 over 5 years with 11 percent interest. Excluded are physicians who 1) die 2) retire because of disability or after age 65 and 3) relocate outside the Commonwealth after completion of their internship or residency.

Section 39: Medical Malpractice Commission Study of Blue Cross and Blue Shield. This could be significant if it ever meets and is serious in its investigation of this service corporation. Besides studying Blue Cross-Blue Shield, is charged with studying a patient compensation fund and the feasibility of an early tender system.

Section 40: Requires the Medicine Board to promulgate regulations of risk management.

Section 40A: Evaluation by the Secretary of Consumer Affairs & Business Regulation annually of the implementation of the Medical Malpractice Act and recommend to the Legislature whether podiatry should be included within its provisions.

It is a small wonder that the Massachusetts Bar Association believes this is good legislation. It re-establishes their belief that the reason for medical malpractice is medical malpractice, and it is caused by bad medicine and physicians, and not an avaricious legal system cloaked as a consumer advocate.

Gregory A. Slachta, M.D.

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The Legend of Bob O'Malley

"A bit of doggerel composed for the occasion of a retirement party for an outstanding surgeon with 35 years of experience" Samuel F. Potsubay, M.D.

Tonight we are gathered to honor a surgeon
Whose scalpel was wielded with consummate skill.
He cut a wide swath in the dermis of Holyoke
And many of us bear a scar of his, still.

A gentleman, always, our Bob was not given,
To making a snide or a cutting remark;
The cutting he did was done in the OR
Or in the emergency room after dark.

With scalpel in hand he was all bent on action
No part of one's body was free from assault
No abscess or ulcer or polyp or tumor
Or worm-like appendix that might be at fault.

No lump in the breast and no cyst went unnoticed.
No stony gallbladder with purulent bile,
No gap in the mid-riff or groin that was bulging,
By him was allowed to just linger awhile.

A loud-gurgling belly to him meant obstruction
and this might be due to adhesions or kink.
He'd pick up with ultrasound aortic blisters,—
with Doppler, clogged arteries, quick as a wink.

Now you'd hardly think that a fellow so gentle
Would stoop to commit such a dastardly act,
But many a patient has had his anatomy
Checked by him, even his low G.I. tract.

The worst part of all this pernicious procedure
Is that it demands an indelicate pose,
With patient half-clad in a scanty, white johnny
While balancing there on his knees and his nose.

While in this position the patient feels helpless;
He's very embarrassed—he feels like a dope;
While Bob plays the role of a U-boat commander
and eagerly peers through a long periscope.

Some surgeons are trained on the fields of athletics
Where courage and skill are the coin of the realm;
At Trinity, Bob was dubbed "Little Caesar"
and his team kept winning with him at the helm.

At P. & S., Bob had had his medical schooling
and one day, as resident there he did spot,
With his roving eye, the "queen of the nurses"
and with winsome Maril he soon tied the knot.

In due course of time, our gross national product
was increased by them by a factor of six,
Who now have left home, but from all directions
Each year get together, to ski—just for kicks.

Now three of the six walked in medical footsteps
and each of the others did just what he'd like;
But all are O'Malleys whose first names are Irish—
Dee, Terry, and Kevin, and Sean, Pat and Mike.

Bob lived in an era when treating the patient
was far more important than treating the chart;
In thirty-five years not an audit committee
Found progress notes dated-or dear to his heart.

No DRG hurdles were then in existence
to hamper the care of the halt or the sick
While third-party payers now deem it important
To stall off admissions and "get 'em out quick"!

While gazing at Mt. Tom, once, Bob had a vision,
and, always the schemer, he cherished the hope
That some day this mountain would serve a new purpose—
and got Dan O'Connell to build a ski slope!

continued on next page

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The Legend of Bob O'Malley

Continued from previous page

Then one day out skiing there, Bob got the idea

That into *Sports Medicine* he'd have a look,
and so with an elderly doctor from Spokane,
on "*Vintage Skiing*", co-authored a book.

At golf he excelled and was one of the best, but
developed a shank and gave up the game

The Trail Appalachian, he began hiking
And covered the whole range and came home quite
lame.

A few years ago, O'Malleys left Holyoke
and built on Connecticut River's east bank;
The efforts of many had cleaned up the river
among them we've Bob and Sue Panitch to thank!

Then Bob realized a new use for the river;

He felt that Mount Holyoke was ripe for a crew.
He sparked "Friends of Rowing," a group of supporters,
and tactfully gave them a few things to do.

Most mornings at sun-up the crew is out rowing

Despite all their studies, the fog, and the cold;
They all want to follow the wake of coach Holly
Who in the Olympics, had brought home the gold!

It's not the athletics of crew at Mount Holyoke

That interests our Bob—but we all know why!
For since his retirement, Bob's always found singing:
"Sitting on the front porch,
Watching all the girls,
Watching all the girls,
Watching "ALL THE GIRLS ROW BY".

Look to us for direction.



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*The Hospice Voluntary Care Giver—
"Someone Special"***Visiting Nurse Association of Springfield**

Like many voluntary home health agencies, the Visiting Nurse Association of Springfield (V.N.A.S.) was increasingly called upon to provide care at home to patients with terminal illness. Most of these patients and their families struggle daily with a variety of problems. Although our nursing staff is able to meet the bulk of these demands, in 1979 it became obvious to us that extra supportive time and attention was often needed.

For this reason, we developed and added a volunteer component to its home care services called the Voluntary Care Giver (V.C.G.) Program. It's emphasis is on hospice-related services required by patients with a terminal illness and their family members. Now in operation for more than seven years, we have found the program to be effective. It provides an additional dimension to our team effort that has enriched not only the patients' and families' lives, but the care given by nursing staff members as well.

A patient's description of a Voluntary Care Giver provides a special affirmation of the program's purpose. "A Voluntary Care Giver (V.C.G.) is an individual willing to give of himself or herself to bring joy, life, and happiness. The V.C.G. participates in the program willingly and does not consider the role as a task nor does a V.C.G. look for financial reimbursement. A V.C.G. wants to share with others. Let me give you an example of how a V.C.G. helped me have a good day. I have been ill a long time and one thing I used to enjoy doing was to cook. The V.C.G. planned ahead and stocked my kitchen with the appropriate items so that I could participate from my wheelchair to make my gumbo. People were having fun. I could forget my illness and accept the day for what it was. There was a sharing of love. This is a specific example of someone knowing my interest and helping me to plan ahead so that there could be a spontaneity which brought me much joy."

The care of the dying must be a team concern. Voluntary Care Givers are part of the network of cooperative disciplines that include the dying patient, his or her immediate family, the doctor, the clergy, the nurse, the social worker, the home health aide, the volunteer, and other health care personnel.

Each volunteer is carefully screened and selected by evaluating his or her reasons for participating in the program, past experiences with death, recent life changes, feelings toward the medical profession, and exploration of his or her religious views.

In the fall of each year, there are eight training sessions plus home-visit observations with nurses in the field for those volunteers being considered for direct patient support. Each individual is scheduled for regular evaluation meetings and attends support group meetings monthly.

Voluntary Care Givers give the patient the desire to be. By stimulating the patient's sense of self worth and confidence, he or she can remain a total person — and that's something special.

Diane Gonyea, R.N.

“Who’s on First?”

This interesting exchange of correspondence took place earlier in the year, but we print it in the light of subsequent events evident to the reader. We make no effort to separate “tongue - in - cheek” comments from underlying truths.

The Editors

January 17, 1986

Massachusetts Blue Shield
100 Summer Street
Boston, MA 02106

Dear Sirs:

In recognition of your willingness to help Massachusetts physicians cope with the malpractice crisis, we are submitting the following invoice.

“Supplemental for Malpractice Premium Increase
1983-1984”

Please pay \$4,693.60.

This figure was arrived at in the following fashion:

Malpractice premiums are 10% of operating expenses (Overhead). Overhead expenses are 53%. 10% of the 53% is for malpractice insurance. The amount Blue Shield paid us for the period July 1, 1983 to June 30, 1984 was \$170,633.00. This figure is based on Forms 1099 for 1983 and 1984, enclosed (50% of each year added together).

Therefore:

\$9,043.55 of this \$170,633.00 went for malpractice overhead. (53% of 170,633.00 = \$90,435.49 went to our overhead expenses, 10% of this amount went to malpractice insurance \$9,043.55).

51.9% of \$9,043.55 is \$4,693.60, your supplemental obligation.

This invoice will be payable (either in full or in quarterly installments at the cost of 4% of the full premium) thirty days after receipt.

Of course, if the JUA appeal defers the obligations of Massachusetts physicians to pay the supplemental premium (1983-1984), this invoice may be discarded.

Sincerely yours,

Charles W. Cahill, M.D.
Treasurer

March 10, 1986

Charles W. Cahill, M.D.
Treasurer
Valley Obstetrical and Gynecological Associates, Inc.
125 Liberty Street
Springfield, MA 01103

Dear Dr. Cahill:

Your letter of January 17, 1986 was forwarded to me for response. The method by which you calculated Blue Shield's supplemental obligation to you for your malpractice premium increase for 1983-1984 was of great interest to me. It would be helpful if you could provide me with some additional pieces of information regarding your practice so that I might be able to complete a more thorough analysis of your methodology. The figures which would be useful in my analysis would be gross and net income of your practice, and percentage of your gross income by type of payor (including Medicaid and Medicare.)

As you are aware, Blue Shield recently received the approval from the Commissioner of Insurance and has implemented a program to increase the payment for the normal delivery to that of the Caesarean section. Medicaid has instituted a similar program. It would be of interest to me to calculate the additional funds those increases will bring to your practice annually. For that analysis, I need to know the number of normal deliveries billed to Blue Shield and Medicaid by your practice in 1985.

Thank you for your help with this analysis. I look forward to hearing from you.

Sincerely,
Jean L. Milton

INGRID SCHWEIGER, Ed.D.

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Jean L. Milton
Executive Assistant
Office of the President
Blue Shield of Massachusetts
100 Summer Street
Boston, MA 02110

March 14, 1986

Dear Ms. Milton:

In response to your letter of March 10, 1986, the following points are relevant:

1) The method of calculation of the supplemental obligation is self-explanatory. The income to the corporation from Blue Shield for the year 1983-1984 reflects the amount of risk the corporation took in providing services for patients covered by BS.

2) Actually the risk is an underestimation since it is based on reimbursement. Blue Shield's unique ability to fix prices at a level far below all other insurance plans make the dollar amount a factor that must be multiplied by a number greater than 1 in order to make the result comparable to reasonable reimbursement.

3) The gross and net income of this practice is not relevant

to this calculation. It is also none of your business. Blue Shield's arrogant secrecy concerning Physician Profiles has set the example for any exchange of information.

4) Blue Shield's generous offer to increase the normal delivery fee is only \$170 LESS than the Medicaid fee (and at least 30% less than all the other payors) is as insulting as it is poor judgement.

5) The number of normal deliveries billed to Blue Shield for 1985 is information that you have. The other information is none of your business. If you are so interested in calculating something, try calculating how much Blue Shield has withheld from physicians in reimbursement for the past 5 years by price-fixing. Then calculate how much BS has withheld from the Government through its non-profit tax status.

6) Your analysis is none of my concern. Your company will be none of my concern after 15 December 1986, when our contract expires.

Sincerely yours,
Charles W. Cahill, M.D.
Treasurer

Dr. Cahill's Formula How to Calculate Your Retroactive Blue Shield Bill for 1983

line 1	\$ _____	Blue Shield Payment for 1983 Jan. 1st-Dec. 31st (Income Tax Form 1099)
line 2	\$ _____	Blue Shield Payment for 1984 Jan. 1st-Dec. 31st (Income Tax Form 1099)
line 3	\$ _____	Blue Shield Payment for July 1st-June 30th 1983 (Line 1 + Line 2 $\times$ 0.5)
line 4	\$ _____	% Overhead (office expenses divided by Income)
line 5	\$ _____	% Malpractice Overhead (Malpractice expenses divided by office expenses)
line 6	\$ _____	'Blue Shield Overhead' multiply line 3 by line 4
line 7	\$ _____	'Blue Shield Malpractice Overhead' multiply line 6 by line 5
line 8	\$ _____	'Retroactive Blue Shield Bill' multiply line 7 by 51.9%

Line 8 is the amount Blue Shield Owes you

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Health Issues of the



These reports bring you information on what the AMA is doing, on behalf of the profession and the public, to influence decisions that will affect health care in the next decade and beyond.

Healthy Lifestyles: One Answer to Controlling Health Care Costs

Americans are getting stronger. They are more interested in eating better, exercising more and providing a cleaner, safer environment for themselves and their children. They need and want information that will help them live longer, healthier lives.

The American Medical Association is meeting that need. In fact, the AMA is convinced that one answer to cutting the costs of medical treatment is prevention: heading off many of the problems which will ultimately require medical care. But cost is not the only concern; this type of public effort is at the heart of the AMA's commitment to "promoting the art and science of medicine, and the betterment of the public health."

Targeting the Nation's Number One Killer. The AMA is working on many fronts to help Americans develop healthier lifestyles. One of its major thrusts is to eliminate smoking, which the U.S. surgeon general has labeled "the number one preventable cause of death." Smoking contributes to more than 340,000 premature deaths a year, including 30 percent of all cancer deaths. It is behind millions of debilitating chronic diseases; it is a major risk factor in cardiovascular disease, chronic bronchitis and emphysema; and it causes cancer of the lung, throat, mouth, esophagus, pancreas and bladder.

The AMA is committed to working with the profession, the government and educators to make society "smoke free" by the year 2000. Some of the measures already adopted by the House of Delegates include having the AMA:

- Urge Congress to strengthen warnings on cigarette packages to include messages that smoking 1) causes cancer of the mouth, larynx and lung; 2) is a major cause of heart disease and emphysema; 3) is addictive; and 4) may result in death;
- Ask the U.S. surgeon general to place health hazard warnings on snuff and chewing tobacco packages, and to study the safety and efficacy of nicotine chewing gum as an aid to smoking cessation;
- Encourage physicians to establish a policy to publicize the hazards of smoking, and to schedule extra time to explain the health risks of smoking to their patients.

Alcohol: A National Nightmare. The AMA is also addressing the problems of alcohol—the number one drug of abuse in our society. Alcohol abuse adversely affects all body systems. It has been linked to hepatic cirrhosis and to cancers of the upper alimentary and respiratory tracts.

This insidious killer is also implicated in nearly every type of traumatic death studied. In one city, a recent study showed that 51 percent of homicide victims were legally intoxicated; 70 percent had positive blood alcohol concentrations. Of the 48,609 deaths that occurred on the nation's streets and highways in 1981, 20,658 (or 43 percent) were known to involve alcohol.

Alcohol's damage can be measured in monetary terms, as well. It is estimated that in 1983,

the total costs to society for alcohol-related treatment, lost life and productivity, property loss, crime and welfare were \$116.7 billion.

The AMA is taking strong steps to fight alcoholism. Its *Manual on Alcoholism* and the *Manual on Drug Abuse* provide physicians with valuable information on treating alcoholism and other addictive disorders. The Association has sponsored conferences on impaired physicians to alert the profession to the problem within its own ranks. The AMA has established a standing Panel on Alcoholism within the AMA Council on Scientific Affairs, which in 1982 adopted a report and recommendation on fetal alcohol syndrome. The AMA also supports state and federal legislative efforts to strengthen drunk driving laws and their enforcement.

A Multi-Faceted Effort. The AMA is working on other fronts, as well. The AMA provides information to the public and the profession on the importance of nutrition. One of the most critical aspects of this program is fighting the misinformation and "pseudoscience" attached to nutritional needs.

The AMA is also pursuing greater automobile safety. The AMA House of Delegates supports mandatory seat-belt use, mandatory child-passenger restraint laws, immediate implementation of a mandatory air bag program, and legislation to promote the availability of seat belts in school buses and in all motor vehicles carrying passengers.

Moreover, the AMA is committed to supporting efforts aimed at the prevention of childhood diseases through immunizations, safeguarding the environment and decreasing pollution, examining occupational health problems and looking at the health risks of energy generation, among many other concerns.

Physicians who want to involve themselves personally in this battle have the perfect avenue—they can join the AMA. Only the AMA has the unity, strength and leadership to promote wellness on a national scale. Membership in the AMA gives you a voice in making decisions which affect the public welfare. If you have a commitment to the future health of this nation, join the AMA.

Join Your Medical Societies Today

For more information, call the AMA, toll-free, 800/621-8335 and in Illinois, call collect 312/645-4783. Or return this coupon to: AMA Division of Membership, 535 N. Dearborn, Chicago, IL 60610.

☐ Please send me AMA membership information. I am a member of my county medical society.

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Notes & Quotes of Interest

STATE AND LOCAL AGENCIES WILL TARGET WOMEN'S ISSUES: Springfield. The U.S. Food and Drug Administration, Boston, March of Dimes, American Lung Association of Western Massachusetts, Springfield YMCA, and other agencies from Hartford and Springfield will participate in the October 29, 1986 FOCUS ON THE CONTEMPORARY WOMAN forum designed as an up-to-date program dealing with the top ten issues affecting women. Designed for the allied health professional, educators, community leaders and the contemporary woman, the program is to be held at the Holiday Inn, Ingelside Mall off Route 91, Holyoke, Massachusetts from 9:00 - 4:00 p.m. Cost is \$40.00 per person. Pre-registration is required.

Continuing Education Units (CEU's) have been applied for. For program and registration information call or write to: Diane DiPiero Saia, Chairperson, 1986 Focus on the Contemporary Woman, F.N.C., 55 State Street, Springfield, MA 01103 (413) 737-1935.

PRO MONITORING PROJECT: The American Medical Association is once again urging physicians to relay their experiences, both positive and negative, with Peer Review Organizations, to its headquarters office in Chicago. The PRO Monitoring Project, initiated in March 1985, is part of an ongoing Association activity to keep appraised of developments in the implementation of the federal government's PRO program. Through the project the AMA, to date, has received over 200 written communications on PRO's representing the concerns of more than 5,000 individual physicians nationwide.

While the AMA is interested in all relevant experiences, areas of particular interest would include:

- changes in length of stay, admission and discharge policies
- preadmission certification procedures
- notifications to patients on payment denials
- utilization and quality review results
- administrative relations between hospitals and physicians and the PROs
- any demonstrable impact the PRO review may have on the cost or quality of care
- sanction activities
- appeals processes
- the results of any PRO efforts to review patients other than Medicare beneficiaries.

Physicians or hospital medical staffs who would like to share this information with the AMA are encouraged to describe their experience(s) in a brief letter and direct it to:

AMA PRO Monitoring Project
Department of Health Care Review
American Medical Association
Post Office Box 10947
Chicago, Illinois 60610

All sources of information provided will be kept confidential. The data will be carefully analyzed and the results used by the AMA as the Association develops new ways to assist physicians and medical staffs in dealing with the PRO program.

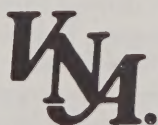
NLM's DOCLINE SOON TO BE AVAILABLE IN REGION I (EAST COAST): DOCLINE, the National Library of Medicine's automated interlibrary loan request and referral system, which has been in operation in Regions 2, 3 and 7 will soon be available in Region I.

The DOCLINE system was developed to accommodate a quicker and more efficient Interlibrary Loan System throughout the nation. The system is divided into cells; cells ranging from the local consortium to the final source, the National Library of Medicine. The first cell contains libraries most frequently used; the second cell contains libraries carrying holdings beyond what the small hospital library carries; the third cell contains large medical libraries, i.e. Countway, Columbia Medical Schools, New York Academy of Medicine. At present the fourth cell is unfilled and the fifth cell contains the National Library of Medicine. In essence, the DOCLINE database will search until locating the source carrying the required copy and automatically put in the request.

At present, filling an interlibrary loan involves finding the library that carries the requested issue of the journal, they will send it on to another library in the Union List that carries the journal. Frequently, by the time the copy is received, the physician no longer has any use for it. Through DOCLINE, the librarian will know the next day if the request has been accepted and can expect the copy in the mail within the next few days.

There will be no charge for DOCLINE for the first year. The target date for operation in Region I is November 1st, 1986.

continued on next page



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Notes & Quotes of Interest

continued from previous page

MEDLINE SEARCHES AVAILABLE THROUGH SPRINGFIELD ACADEMY OF MEDICINE: In September the Springfield Academy of Medicine will be offering the services of MEDLARS (NLM's Medical Literature Analysis and Retrieval System) to the medical community as a whole.

In July, I attended a five day online database training course for medical librarians sponsored by the NLM at Dartmouth College in Hanover, New Hampshire, not only to learn to do medical searches but to be able to qualify as a Medlars subscriber.

MEDLARS provides access to Medline, a general medical database which contains over 650,000 current files spanning a two year period and back files to 1966 containing over a million citations.

MEDLARS also offers access to other databases such as Toxline which has a database containing over 50,000 sources, PDQ (Cancer Treatment) which has over 67,000 sources of reference and Health Planning Administration which carries 29,000 sources, as well as many other medical related databases. These database sponsored by MEDLARS carry charges that vary according to the database, i.e. TOXLINE \$75.00 per hour, CHEMLINE \$110 per hour, MEDLINE \$20.00.

The cost of a Medline search will be \$5.00 for members of HDMS and \$15.00 for non members. Once the funds from the MMS grant are made available in 1987, a reassessment of charges to members for searches will be made. Manual searches will remain free.

The library is open Monday thru Friday, 9 a.m. to 4 p.m. to serve your medical literature needs.

M. Stoler

ACTIONS OF THE AMERICAN MEDICAL ASSOCIATION (AMA) HOUSE OF DELEGATES—1986 ANNUAL MEETING HELD IN CHICAGO, JUNE 15-19

I. QUALITY ASSURANCE ACTIVITIES

A. AMA Initiative on Quality-of-Medical Care and Professional Self-Regulation

In an initiative designed to strengthen its quality assurance activities, the AMA has called upon all physicians to renew their commitment to report professional misconduct and incompetence and to participate actively in peer review.

In a report adopted by the AMA's House of Delegates, the Association said "the profession can and must do more" to control professional incompetence and misconduct. The challenge is to "continue to exercise leadership in improving quality assurance systems in an environment in which concerns of cost and economics have become predominant."

To this end, the AMA resolved to expand its activities by broadening quality-of-care issues to include developing a definition of quality care and guidelines for measuring it; designing improved peer review and quality assurance systems and reviewing standards for medical education.

The AMA also announced that it would expand and improve its physician data bank so that any hospital medical staff or other appropriate organizations seeking to verify the credentials and practice history of any physician could receive complete record verification within one week of requesting this information.

The AMA report also noted that the public "tends to measure the effectiveness of quality control by the number of official license revocations by state medical disciplinary boards." On that measure, it says, "the record is not good overall." Physicians, fearing personal liability suits, "are reluctant to report incompetent colleagues to state medical boards" while adverse hospital review determinations "too often stay within the hospital." The report concluded that "peer review can be more careful, vigorous and uniform," and that "too little scientific evaluation of the efficacy of quality assurance and risk management programs has been undertaken."

In a related action, the delegates referred a resolution to the AMA Board of Trustees that would explore the possibility of creating a national computer file on physicians who have had disciplinary actions taken against them. The file would have strict safeguards to insure that the information is accurate, is used only for legitimate purposes, and collected with the knowledge of the physician involved, who would have the opportunity to correct any errors in the information. The system also would allow for the deletion of recorded disciplinary actions that were consequently reversed.

B. Quality-of-Care Assessment Guidelines

Drawing from a report prepared by the Council on Medical Service, the AMA has endorsed eight essential elements of quality care that it believes will provide a logical framework for organizing professional assessment programs.

The report also observed that the heart of any program assessing the quality of medical care is peer review or the evaluation by practicing physicians of the quality and efficiency of services ordered or performed by other practicing physicians. It noted that AMA's 1982 Interim Meeting, the delegates adopted nine principles for voluntary medical peer review.

The latest guidelines suggested by the Council and adopted by the House of Delegates are intended to supplement those principles and to assist further in the development of effective peer review programs. According to the report, these guidelines should be incorporated in any peer review system, whether voluntary or government-mandated. They are:

- The criteria used to judge the quality of medical care should be developed and agreed on by the professionals whose performance will be reviewed.
- Such criteria can be derived from any one of three basic variables of care: structure, process or outcome. However, emphasis in the review process should be placed on establishing a connection between specific elements of structure and process and favorable outcomes rather than on the isolated examination of each variable.
- To isolate better the effects of structure and process on outcome, studies should be conducted on a prospective as well as retrospective basis whenever possible.
- The evaluation of "intermediate" rather than "final" outcomes is an acceptable technique in the quality assessment.
- Blanket review of all medical care provided is neither practical nor needed to assure quality care. Reviews can be conducted on a targeted basis (e.g., specific diagnoses, services or

providers), a sampling basis or a combination of both, depending on the goals of the review process.

- Both explicit and implicit criteria are useful in assessing the quality of care.
- Prior consultation, concurrent and retrospective peer review are all valid aspects of quality assessment.
- Any quality assessment program should be combined with a quality assurance system so that assessment results can be used to improve performance.
- The quality assessment process itself should be continually evaluated and modified as needed.

In its recommendations, the Council said that it planned to evaluate the effectiveness of various approaches to quality assurance and the use of assessment findings to improve the care delivered with the goal of increasing access to high quality medical care. All such quality assurance systems must be sensitive to the differences among patients with ostensibly the same condition and should evaluate overall practice patterns rather than specific criteria in single cases.

C. Prior Authorization Programs

The AMA has adopted a set of principles for evaluating preadmission review programs to minimize any potentially detrimental impact of such reviews on the quality and accessibility of care. The AMA noted that voluntary, focused, physician-directed preadmission review programs are preferable to mandatory, blanket review programs imposed by the government on third-party payors. The principles for evaluation are:

- Blanket preadmission review of all or the majority of hospital admissions does not improve the quality of care and should not be mandated by government, other payors or hospitals.
- Review policies should be established by state or local physician review committees and the actual review should be performed by physicians or under the close supervision of physicians.
- Any decision to deny hospital admission should be reached only by physician reviewers and only after the reviewing physician has discussed the case with the attending physician.
- Physicians and insured patients should receive direct and continuing communication about prior authorization requirements.
- All preadmission review programs should provide for immediate hospitalization, without prior authorization or subsequent denial of payment based on lack of such authorization, of any patient whose treating physician determines the admission to be an emergency.

• No preadmission review program should make a payment denial based solely on the failure to obtain preadmission review or solely on the fact that hospitalization occurred in the face of a denial for such admission.

• Payors who institute preadmission review requirements as a condition for receipt of plan benefits should be subject to legal action for any harm incurred by the patient resulting from the application of such requirements.

• When inordinate amounts of physician time or effort are involved in complying with preadmission review requirements, the physician may charge the payor or the patient for the reasonable cost incurred.

The report also said that the AMA's Council on Medical Service has been meeting with payors, employers, third parties and other concerned groups to explore the possibility of greater uniformity in administration and notification procedures for both preadmission certification and second surgical opinion programs. It is also said that the Health Insurance Association of America and the National Blue Cross and Blue Shield Association have made a commitment to explore methods to alleviate some of the administrative problems caused by preadmission review to bring some uniformity to these programs.

In a related action, the delegates adopted a resolution to seek standardization of administrative procedures for preadmission certification programs, including both the administrative requirements to be met and the forms to be completed. (See Quality Healthcare Programs Bulletin #2-86: "Prior Authorization Programs.")

D. Liability for Injuries to Patients to Review Decisions by Third-Party Payors

This report, developed by the council on Medical Service and adopted by the House of Delegates, recommends the development of legislation that would require peer review organizations, fiscal intermediaries, insurance companies and other third parties to accept liability and financial responsibility for injuries to patients resulting from improper review decisions. The report highlights that Louisiana enacted legislation which holds the insurer/self-insurer liable for harm to the insured resulting from unreasonable delay, reduction or denial of proposed medical services or care occasioned by the prospective review of medical necessity by the insurer, self-insurer, third party administrator or independent contractor. Minnesota amended its peer review immunity statute to make any federal peer review organization subject to action for damages or other relief when a patient fails to

continued on next page

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Notes & Quotes of Interest

continued from previous page

receive care as a result of a determination by the PRO that medical care was unnecessary or inappropriate.

The report recommends that the AMA develop model state legislation which would ensure that any payor using a utilization review committee provide sufficient insurance to pay for liability arising from actions of the committee that caused or contributed to the injury of an injured person. In the opinion of the Council, this provision would encourage payors to make certain that their requirements for prior or continuing approvals are reasonable.

II. HEALTH INSURANCE ISSUES

A. Employers' Violation of Patient Privacy with Group Medical Insurance Claim Forms

Another Council on Medical Service report adopted by the House, concerns the issue of confidentiality of employees' medical information. The report recommended that the AMA urge employers and health insurers to adopt policies and practices to preserve the confidentiality of employees' medical information. The report also called for the AMA to oppose employment discrimination based on health conditions not related to job requirements and based on use of health benefits. It urged the development of legislation to carry out this policy.

B. Reimbursement for Diagnostic Studies Identified as Surgical Procedures

Another Council on Medical Service report adopted by the House responded to resolutions asking AMA to support differentiation between diagnostic and therapeutic surgical procedures by private and public payors. The report recommends that the AMA support differentiation of these procedures when appropriate.

C. Denial of Payment for Medical Services Based Solely on Fiscal Considerations

This resolution, adopted by the House, calls on the AMA to oppose any law, rule, regulation, or third party decision that denies payment solely on the basis of fiscal considerations. The AMA's opposition will be communicated to na-

tional health insurance associations and involved government agencies.

III. MEDICARE

The AMA accepted a Board of Trustees proposal to reform the financing of health care for the elderly. According to the trustees, Medicare should be redesigned as a prefunded, fiscally-sound program offering catastrophic protection, benefits based on ability to pay and free choice options among differing health plans.

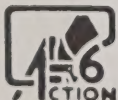
The Board's report emphasized that prefunding of Medicare should eliminate previous funding flaws, while stabilizing Medicare costs by the late 1990's. The report adopted by the House would provide for:

1. Universal eligibility based on age
2. Protection of access through prefunding
3. Catastrophic protection
4. Means testing, with limits on out-of-pocket expenses for most beneficiaries set at \$2500 per year for individuals, or \$3750 per year for couples.
5. An annual voucher for the purchase of an adequate benefits policy from an approved insurer or health plan that would differ according to geographic region and include an applicable deductible and coinsurance provision.
6. A tax code allowance for an additional \$500 contribution to an individual retirement account to cover health expenses that may be withdrawn tax free after the beneficiary reaches eligibility age.
7. A gradual increase in Medicare eligibility from the current age 65 to age 67.

The proposal calls for financing a new program with an initial tax of 1.75% on adjusted gross income—an increase from the current 1.45%. There also would be an increase of less than 1% on employer taxes to fund Medicare. The Board of Trustees report is a response to resolutions presented to the AMA House of Delegates at the 1985 Interim Meeting, which called on the AMA to review the current Medicare program with an eye to ensuring quality while assuring continued fiscal soundness.

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1221 Main St.
Holyoke, MA 01040

BORN: December 28, 1948
PREMED: Hunter College 1966-70
MEDICAL: Rutgers Medical School 1970 - 74
INTERNSHIP: Beth Israel Medical Center 1974-76
RESIDENCY: Hospital for Joint Diseases, Orthopedic Institute 1976-80
FELLOWSHIP: Boston City Hospital 7/80-12/80
SPECIALTY: ORTHOPEDIC SURGERY/HAND SURGERY

Cyrus Dabiri, M.D.

759 Chestnut Street
Springfield, MA 01107

BORN: July 12, 1941
PREMED: Tehran University 1960-63
MEDICAL: Tehran University School of Medicine 1963-67
RESIDENCY: Hahnemann Medical College and Hospital 1969-70
FELLOWSHIP: New Born Medicine 1971-74
SPECIALTY: PEDIATRIC NEONATOLOGY

Molly J. Noonan, M.D.

305 Bicentennial Highway
Springfield, MA 01108

BORN: December 19, 1947
PREMED: Manhattanville College 1965-69
MEDICAL: Harvard University 1976-78
University of Pennsylvania
Case Western Reserve University 1978-82
INTERNSHIP: Cleveland Metropolitan General Hospital 6/82-6/83
RESIDENCY: Cleveland Metropolitan General Hospital 7/83-6/85
SPECIALTY: INTERNAL MEDICINE

Nancy D. Baker, M.D.

444 Montgomery St.
Chicopee, MA 01020

BORN: July 23, 1940
PREMED: Long Island University 1958-62
MEDICAL: New York Medical College 1963-67
RESIDENCY: St. Vincent's Hospital, New York 1968-72
FELLOWSHIP: Hospital for Joint Disease, NYC 7/72-7/73
SPECIALTY: DIAGNOSTIC RADIOLOGY

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Lawrence E. Schwartz, M.D.

759 Chestnut Street
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RESIDENT

BORN: January 9, 1958

PREMED: Ohio State University, 1976-80
Wright State University, Ohio
1980-82

MEDICAL: Medical College of Ohio, Toledo
1982-86

INTERNSHIP: Baystate Medical Center 6/86

Bruce H. Kittrick, M.D.

759 Chestnut St.
Springfield, MA 01107

RESIDENT

BORN: December 8, 1954

PREMED: Evergreen State College Olympia,
WA 1976-80

MEDICAL: University of Washington, Seattle
1981-86

INTERNSHIP: Baystate Medical Center 7/86

Jacqueline M. Baez, M.D.

50 Maple St.
Springfield, MA 01103

BORN: April 11, 1944

PREMED: University of Santo Domingo

MEDICAL: Universidad Autonoma de Santo
Domingo 1960-67

INTERNSHIP: Toledo Hospital 7/69-7/70

RESIDENCY: Medical College of Ohio 1970-71

Wesson Women's Hospital 1971-74

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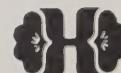
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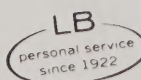
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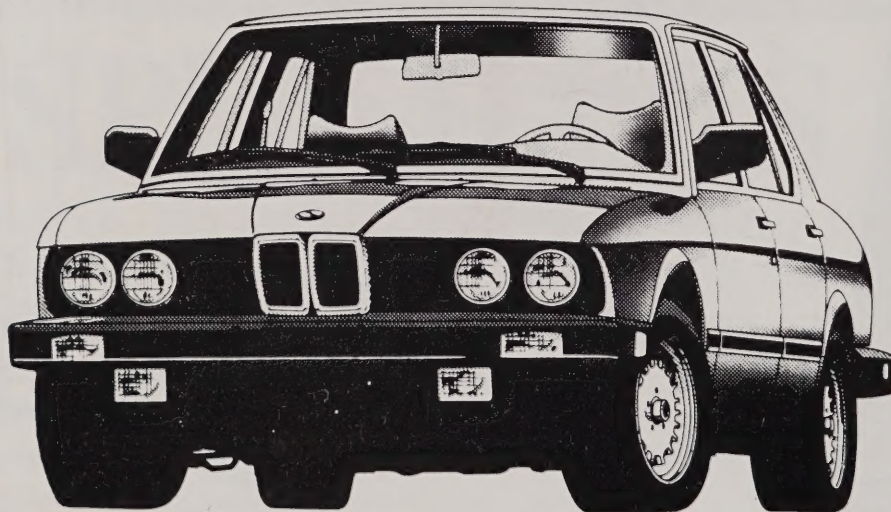
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